ABC: a natural, indigenous response to AIDS

Presented at the XV International AIDS Conference, special USAID Satellite Session, Bangkok, Thailand 7/11/04

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new truths from AIDS experts

Several comments are being voiced in recent months by world-renowned AIDS experts:

- Treatment is an integral part of prevention; you cannot have prevention unless the drugs are there to treat people with HIV
- ABC can work, but only if its part of a comprehensive program that includes drugs for treatment of standard STIs

These statements sound authoritative, but are they true?

I don’t want to suggest that drugs for HIV or for standard STIs are not desirable to have.

But that is not the same as asserting that drug availability is necessary for AIDS prevention to work (cf. Piot, Feachem, Lee, and Wolfensohn 2004 in *Science*), or for ABC to work.

And then there is the question raised in this symposium, namely what are the relative contributions of A, B and C interventions and behavioral changes in HIV prevalence decline?

To shed light on these issues, it should be recognized that there were great regional (district) differences in intensity and timing of preventive interventions in Uganda

the epidemic began in the south western part of Uganda and then spread rapidly to the east and to the north. Thus, infection rates peaked somewhat later in the east and north, before starting to decline

According to the 2002 HIV/AIDS surveillance report for Uganda, prevalence fell in:

- Moyo district from 5.0 % to 2.7 %
- in Pallisa district from 7.6 % to 3.8 %
- in Soroti from 9.1 % to 5.0 %;
- in Matany (Moroto) from 7.6% to 1.7 %
  - (7.6% is an outlier figure in the data and may have been due to picking up some non-Karamajong who were in the area. The figure might have been more like 4% for people native to the area)

Consideration of these data in districts of relatively low seroprevalence weakens the argument that Uganda's HIV seroprevalence decline might have been caused either by reaching the saturation stage of the epidemic or by firsthand experience with dying and dead family members, rather than behavior change (A, B or C changes) linked to interventions

Karamoja area (2 districts in extreme northeast of Uganda)

Has the lowest HIV prevalence in Uganda- 1.7%

Has experienced a 60% or more decline in HIV prevalence

Has not benefited from standard AIDS prevention, due to war, insecurity, remoteness

Karamoja can be considered a natural experiment of what can be done in the absence of condoms and drugs

What happened to reduce prevalence in Karamoja?

- The people are not Muslim
- they do not practice male circumcision
- a random sample survey (by the MOH) in 1997 found:
  - 74.5% had no formal education;
  - 74% had never listened to a radio;
  - 88.6% had never seen television;
  - Only about 16% had read a newspaper at least once a week.

(focus group comment: "**the radio impact has done very little in Karamoja because of poor listenership**")

Northern Uganda Area, Karamoja
From MoH KABP Survey, 1997

Seroprevalence fell from c. >4% to 1.7%, 1991-2002

Condom Use: 3% ever-use, M+F

Age of sexual Debut: 18.2 (men and women combined)

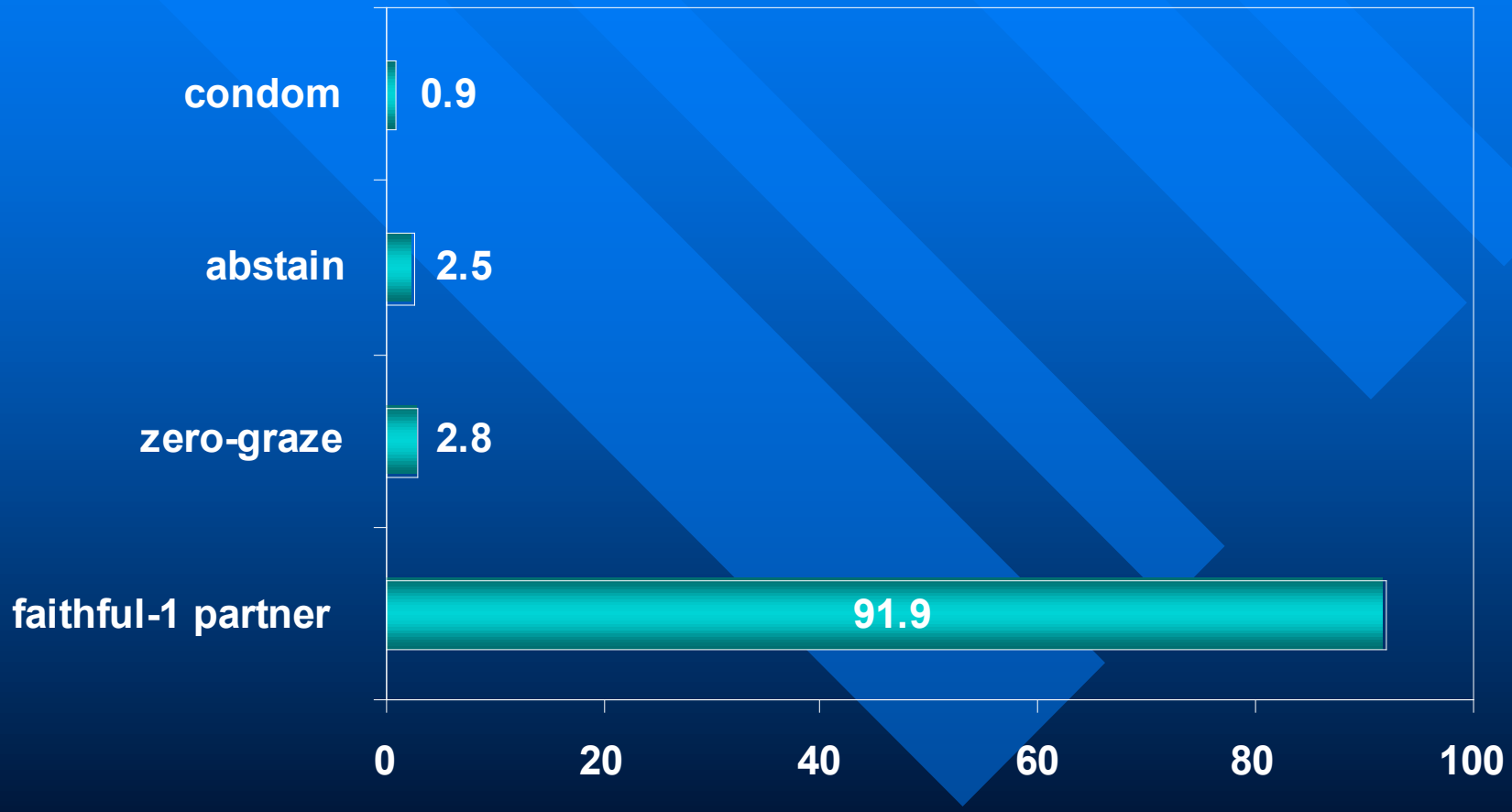
Reporting non-regular sex partners: 1.9% in Karamoja, 1997

almost everyone reporting "A or B" behaviors (see next slide)

Yet earlier studies suggest fairly high rates of multipartner sex prior to AIDS

What happened to change this?

"Have you changed your sexual behavior due to AIDS? If so, How?" (1997)



Sources of AIDS knowledge

AIDS awareness was found to be higher than might be expected in 1997: 88% had heard of AIDS and 65% were able to cite at least two major means of prevention. Unfortunately, respondents were not asked about the source from which they had learned about AIDS.

But I recently (May-June 2004) explored this and other questions through key informant interviews and focus groups involving men and women. (All interviewers were Karamajong)

Sources of AIDS knowledge

Sources are: friends, neighbors, parents, churches (religious leaders), teachers, local leaders, TBAS, awareness raising meetings & drama shows

In other words, there was a great deal of informal, face-to-face IEC based in local communities. Stoneburner & Low-Beer 2004, Green 2003 show that this type of intervention predominates in Uganda. What is different about Karamoja is that these interpersonal contacts are virtually the ONLY sources of AIDS knowledge

How Behavior Changed

Representative verbatim comments from my focus groups & key informant interviews show how behavior has changed in recent years:

"Men no longer sleep with anyone; they are faithful to their women. Rape is punishable by 8 cows and adultery by 60 cows. Virginity is highly valued, and high bride prices prevents women from having sex before marriage. Prostitution is not allowed in our society.“

“There is no fornication in Karamoja.” The number of men involved in protected sex by using condoms has risen.

But maybe low & declining prevalence in Karamoja is due to some other factors?

Well, we have a similar example from Zambia, i.e., a district that stands out by having much lower HIV prevalence than the rest of the country

Zambia's Northern Province

has the lowest prevalence rate in Zambia: about 8% compared to about 16% nationally;
Circumcision not practiced, but…
it has the highest levels of abstinence and the lowest levels of those reporting 2+ partners in the past year (at least for men. Women exhibit low levels, but not quite the lowest in Zambia);

In two condom measures, i.e. last use with anyone or last use with a nonregular partner, it ranks at about the national averages

This example, and Uganda's Karamoja, help underscore the relative importance of A and B factors and their association with lower HIV prevalence

The Phase One reports of USAID's ABC Study (both Bessinger at al 2003 and Green et al 2003) found that A and B behavioral changes appear to be necessary to reduce population-level HIV prevalence. This cannot be accomplished by increases in condom use alone.

USAID's new ABC policy recognizes this (Dec 2002), as does PEPFAR'S ABC policy

I think the example of Karamoja provides evidence that we can do low cost, low-tech, culturally compatible, and apparently sustainable AIDS prevention interventions in Africa that rely heavily on local and religious leaders, and take a comprehensive ABC approach, with primary emphasis on A and B behaviors.

An aBBc approach seems particularly well-suited to rural Africa, where it is difficult ensuring a steady supply of commodities, and where conditions are different than when targeting high-risk groups like CSW, MSM, IDU.

As Karamoja shows, it is not necessary—although it may be desirable—to have ABC be part of a comprehensive set of interventions that includes treatment (our original question).

Regarding the other original question: Karamoja shows that there can be widespread behavioral change and prevalence decline even in the absence of treatment--even in the absence of condoms.

A& B behavioral changes are already happening…

..even without resources put into A&B interventions. When African governments (or local organizations) are left to their own devices, they tend to promote ABC. They do not restrict themselves to the medical model that relies on condoms and drugs. Why? (some reasons are):

- Cultural & religious compatibility of A&B
- Balanced ABC makes public health sense
- Condoms and drugs are not always available in rural areas
- ABC makes it easier for girls and women to become involved in AIDS prevention, compared to condoms only
- It works